

Case Number:	CM15-0082818		
Date Assigned:	05/05/2015	Date of Injury:	03/02/2008
Decision Date:	06/08/2015	UR Denial Date:	04/17/2015
Priority:	Standard	Application Received:	04/30/2015

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Indiana

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 58 year old, female who sustained a work related injury on 3/2/08. The diagnoses have included myofascial pain syndrome, cervical sprain and rotator cuff syndrome. The treatments have included right shoulder injections, chiropractic treatments with some benefit, right trapezius trigger point injections, TENS unit therapy, medicated cream and oral medication. In the PR-2 dated 3/18/15, the injured worker complains of right trapezius, right medial epicondyle and right shoulder pain. She has spasms in right trapezius area. She has trigger points in right trapezius area. She has right medial epicondyle tenderness. She has decreased range of motion in right shoulder. The treatment plan is to refill medications and medicated cream and to request an MRI of right elbow. The injured worker was given trigger point injections in right trapezius musculature during this visit. A urine drug screen was collected at this visit. The last urine drug screen available in the medical records submitted is dated 12/24/14. The injured worker is not taking any opioid medications as of this visit date of 3/18/15.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Retro Urine Drug Screen: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids and Substance Abuse Page(s): 74-109. Decision based on Non-MTUS Citation University of Michigan Health System Guidelines for Clinical Care: Managing Chronic Non-terminal Pain, Including Prescribing Controlled Substances (May 2009), pg 32 Established Patients Using a Controlled Substance.

Decision rationale: MTUS states that use of urine drug screening for illegal drugs should be considered before therapeutic trial of opioids are initiated. Additionally, Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control. Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion) would indicate need for urine drug screening. There is insufficient documentation provided to suggest issues of abuse, addiction, or poor pain control by the treating physician. University of Michigan Health System Guidelines for Clinical Care: Managing Chronic Non-terminal Pain, Including Prescribing Controlled Substances (May 2009) recommends for stable patients without red flags twice yearly urine drug screening for all chronic non-malignant pain patients receiving opioids once during January-June and another July-December. The patient is currently not taking any opioids. The treating physician has not indicated why a urine drug screen is necessary at this time and has provided no evidence of red flags. As such, the request is not medically necessary.

MRI of Right Elbow: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 33-34. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Elbow (Acute & Chronic), MRIs.

Decision rationale: ACOEM states, Criteria for ordering imaging studies are: The imaging study results will substantially change the treatment plan. Emergence of a red flag. Failure to progress in a rehabilitation program, evidence of significant tissue insult or neurological dysfunction that has been shown to be correctible by invasive treatment, and agreement by the patient to undergo invasive treatment if the presence of the correctible lesion is confirmed. For most patients presenting with elbow problems, special studies are not needed unless a period of at least 4 weeks of conservative care and observation fails to improve their symptoms. Most patients improve quickly, provided red flag conditions are ruled out. There are a few exceptions to the rule to avoid special studies absent red flags in the first month. These exceptions include: Plain-film radiography to rule out osteomyelitis or joint effusion in cases of significant septic olecranon bursitis. Electromyography (EMG) study if cervical radiculopathy is suspected as a cause of lateral arm pain, and that condition has been present for at least 6 weeks. Nerve conduction study and possibly EMG if severe nerve entrapment is suspected on the basis of physical examination, denervation atrophy is likely, and there is a failure to respond to conservative treatment. For patients with limitations of activity after 4 weeks and unexplained

physical findings such as effusion or localized pain (especially following exercise), imaging may be indicated to clarify the diagnosis and revise the treatment strategy if appropriate. Imaging findings should be correlated with physical findings. In general, an imaging study may be an appropriate consideration for a patient whose limitations due to consistent symptoms have persisted for 1 month or more, as in the following cases: When surgery is being considered for a specific anatomic defect. To further evaluate potentially serious pathology, such as a possible tumor, when the clinical examination suggests the diagnosis. ACOEM further recommends MRI for suspected ulnar collateral ligament tears and recommends against MRI for suspected epicondylgia. ODG writes regarding elbow MRI, Recommended as indicated below. Magnetic resonance imaging may provide important diagnostic information for evaluating the adult elbow in many different conditions, including: collateral ligament injury, epicondylitis, injury to the biceps and triceps tendons, abnormality of the ulnar, radial, or median nerve, and for masses about the elbow joint. There is a lack of studies showing the sensitivity and specificity of MR in many of these entities; most of the studies demonstrate MR findings in patients either known or highly likely to have a specific condition. Epicondylitis (lateral - "tennis elbow" or medial - in pitchers, golfers, and tennis players) is a common clinical diagnosis, and MRI is usually not necessary. Magnetic resonance may be useful for confirmation of the diagnosis in refractory cases and to exclude associated tendon and ligament tear. Indications for imaging -- Magnetic resonance imaging (MRI): Chronic elbow pain, suspect intra-articular osteocartilaginous body; plain films non-diagnostic. Chronic elbow pain, suspect occult injury; e.g., osteochondral injury; plain films – non-diagnostic. Chronic elbow pain, suspect unstable osteochondral injury; plain films non-diagnostic. Chronic elbow pain, suspect nerve entrapment or mass; plain films non-diagnostic. Chronic elbow pain, suspect chronic epicondylitis; plain films non-diagnostic. Chronic elbow pain, suspect collateral ligament tear; plain films non-diagnostic. Chronic elbow pain, suspect biceps tendon tear and/or bursitis; plain films non-diagnostic. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. The medical records do not indicate any of the red flags that are indicative for an emergency. No plain films were provided that indicated non-diagnostic findings of the chronic elbow pain. The treating physician notes in treatment notes to rule out epicondylitis. Guidelines state specifically not MRI is necessary for epicondylitis. The treatment notes do not indicate other extenuating circumstances to warrant deviation from the guidelines. As such, the request for Magnetic Resonance Imaging (MRI) of the right elbow is not medically necessary.

Retro Trigger Point Injections x 4: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger Point Injections Page(s): 122.

Decision rationale: MTUS states that Trigger Point Injections are "Recommended only for myofascial pain syndrome as indicated below, with limited lasting value. Not recommended for radicular pain." And further states that "trigger point is a discrete focal tenderness located in a palpable taut band of skeletal muscle, which produces a local twitch in response to stimulus to

the band. For fibromyalgia syndrome, trigger points injections have not been proven effective." MTUS lists the criteria for Trigger Points: (1) Documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain; (2) Symptoms have persisted for more than three months; (3) Medical management therapies such as ongoing stretching exercises, physical therapy, NSAIDs and muscle relaxants have failed to control pain; (4) Radiculopathy is not present (by exam, imaging, or neuro-testing); (5) Not more than 3-4 injections per session; (6) No repeat injections unless a greater than 50% pain relief is obtained for six weeks after an injection and there is documented evidence of functional improvement; (7) Frequency should not be at an interval less than two months; (8) Trigger point injections with any substance (e.g., saline or glucose) other than local anesthetic with or without steroid are not recommended. The medical documents do meet some criteria for trigger point injections per MTUS. MTUS specifically states that radiculopathy should not be present by exam, imaging, or neuro-testing. However, subjective complaints of radiculopathy are present on numerous treatment notes. As such, the request for trigger point injection neck is not medically necessary.